

# LITTLE TRAVERSE BAY BANDS OF ODAWA INDIANS

Mailing Address: 7500 Odawa Circle, Harbor Springs, MI 49740

Physical Address: 915 Emmet Street, Petoskey, MI 49770

Phone: (231) 242-1620 / Fax: (231) 242-1635

## CHILDCARE ASSISTANCE CHANGE OF INFORMATION FORM

Applicant Name: \_\_\_\_\_

Section I. Personal Information ☐ Name Change ☐ Address Change ☐ Telephone

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Physical Address: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Work Telephone: \_\_\_\_\_

### Section II. Child Care Needs

Add	Del	Child's Name	Birth Date	Social Security #	Sex	Tribal #	Hours needed
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____	_____	_____	_____

### Section III. Household Information ☐ Income Change\* ☐ Household Member Addition/Deletion

	Name	Social Security #	Action: Explain Change	New Wage
1	_____	_____	_____	_____
2	_____	_____	_____	_____
3	_____	_____	_____	_____
4	_____	_____	_____	_____
5	_____	_____	_____	_____

### Section IV. Provider Information\*

Provider Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

License #\* \_\_\_\_\_ Telephone: \_\_\_\_\_

Type of Care: ☐ Relative Care ☐ Day Care Center ☐ Unlicensed Provider

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\*A change in income or provider will require additional documentation